INELIGIBLE
(any question with a red response)

Grade:_____ Teacher:_____

2017-2018 Influenza Virus Vaccine, Intramuscular Vaccination Consent Form (Child)

Questions? Please contact Melissa Herpel at (281) 742-0624 or call your healthcare provider.
Please complete and return this form (PLEASE PRINT).

Name of person receiving vaccination: _____
LAST FIRST DATE OF BIRTH

Address:_____

City:_____ State: _____ ZIP code:_____

Home phone:_____ Emergency contact number: _____

Mother's name, if under 18: _____ Father's name, if under 18: _____

Guardian, if under 18: _____ Relationship: _____

Please answer each question below.
The answers will be reviewed by a healthcare provider to determine if your child is eligible.

1. Has your child received a flu vaccination before? Yes No
2. How old is your child?____**under age 6 mo**_____
3. Is your child allergic to any part of the vaccine (eggs, egg proteins, gentamicin, gelatin, or arginine)? **Yes** No
4. Has the child ever had a life-threatening reaction to an influenza vaccine? **Yes** No
5. Has your child ever had Guillain-Barré syndrome? **Yes** No
6. Does your child have thrombocytopenia or any coagulation disorder? **Yes** No
7. Does your child have any diseases (for example, cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids or chemotherapy) that lowers the body's resistance to infection? **Yes** No
8. Does your child have any of the following long-term health problems? (CHECK CIRCLE)
   ○ **heart disease** ○ **kidney disease** ○ **metabolic diseases (for example, diabetes)**
   ○ **other (anything other than hayfever or allergies)**

Please let us know if your child has close contact with anyone who has a weakened immune system (for example, an individual who has had a bone marrow transplant and is in a negative pressure hospital room). Please describe:
_____

Allergies/medical alert: _____

Additional notes: _____

Request for administration of Influenza Virus Vaccine for the above-named recipient: I have been given the 2017-2018 CDC Vaccine Information Statement. I have read this document and have no further questions at this time. I understand the risks and benefits of live intranasal influenza vaccine. I request and voluntarily consent that the vaccine be given to _____, of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccine.

Name of child _____ Age of child_____ Today's date _____

Name of parent _____ Signature of parent _____

INELIGIBLE
(any question with a red response)

2017-2018 Influenza Virus Vaccine, Intramuscular Vaccination Consent Form (Adult)

Questions? Please contact Melissa Herpel at (281) 742-0624 or call your healthcare provider.
Please complete and return this form (PLEASE PRINT).

Name of person receiving vaccination: _____
LAST FIRST DATE OF BIRTH

Address:_____

City:_____ State: _____ ZIP code:_____

Home phone:_____ Emergency contact number: _____

Guardian, if under 18: _____ Relationship: _____

Please answer each question below.
The answers will be reviewed by a healthcare provider to determine if you are eligible.

1. Have you ever received a flu vaccination before?	Yes	No
2. How old are you?_____		
3. Are you allergic to any part of the vaccine (eggs, egg proteins, gentamicin, gelatin, or arginine)?	**Yes**	No
4. Have you ever had a life-threatening reaction to an influenza vaccine?	**Yes**	No
5. Have you ever had Guillain-Barré syndrome?	**Yes**	No
6. Do you have thrombocytopenia or any coagulation disorders?	**Yes**	No
7. Do you have any diseases (for example, cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids or chemotherapy) that lowers the body's resistance to infection?	Yes	No
8. Do you have any of the following long-term health problems? (CHECK CIRCLE)		
○ heart disease ○ kidney disease ○ metabolic diseases (for example, diabetes)		
○ other_____		
9. Are you pregnant or nursing?	Yes	No

Please let us know if you have close contact with anyone who has a weakened immune system (for example, an individual who has had a bone marrow transplant and is in a negative pressure hospital room). Please describe:
_____

Allergies/medical alert: _____

Additional notes: _____

Request for administration of Influenza Virus Vaccine for the above-named recipient: I have been given the 2017-2018 CDC Vaccine Information Statement. I have read this document and have no further questions at this time. I understand the risks and benefits of live intranasal influenza vaccine. I request and voluntarily consent that the vaccine be given to _____, of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccine.

Name of recipient _____ Age of recipient_____ Today's date _____

Signature of recipient _____